PHYSICIAN ASSOCIATES
ORLANDO HEALTH

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____ **hereby authorizes the use or disclosure of the individually**
Print Patient/Legal Representative or Parent/Legal Guardian Name

Identifiable health information of _____ **as described herein.**
Print Patient Name Date of Birth

Person/organization authorized to **use/disclose** the information:	Person/organization authorized to **receive** the information:
Name/organization _____	Name/organization _____
Address _____	Address _____
City, State, Zip _____	City, State, Zip _____
Phone _____ Fax _____	Phone _____ Fax _____

For the purpose of: ☐ Legal Request ☐ Moving out of Area ☐ New Local Physician ☐ Other (please specify)
_____

This authorization will expire on the following date, event or condition: _____
If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Mental health, alcohol, drug, HIV and/or AIDS information is confidentially protected by Federal and state law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. I further request that no genetic counseling/testing information in my record be released without my written authorization, except as otherwise required by law. I understand **that I may select the information from the list below to be released by placing my initials in the space provided. Furthermore, I understand that any disclosure of information from my records carries with it the potential for an unauthorized re-disclosure of my health information.** I further understand that Physician Associates, LLC may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

Date(s) of Service: **From:** _____ **To**: _____

Place your INITIALS by each item to be released or reviewed:

____ Abstract of Record ____ All diagnostic test results ____ Pathology/Operative Report(s)
____ Radiology only ____ Consultation/Progress Note(s) ____ Lab only
____ Complete Record (charges may apply) ____ Other (specify) _____

In addition, place your INITIALS by each specific item: (if applicable)

____ Mental Health ____ HIV Testing ____ Genetic Counseling/Testing Information
____ Drug and/or Alcohol ____ AIDS Information ____ STD/Communicable Diseases

_____ _____
Patient/Legal Representative or Parent/Legal Guardian ***Signature Required*** Date of Authorization

_____ _____ _____
Patient Date of Birth Social Security Number (optional) Identification Shown

_____ _____
Translator or Interpreter's Name Telephone Number

_____
Address City State Zip Code

Official Use Only: _____
Name of Person Releasing Information **Date**